



***Color Me Healthy:
A Profile of Michigan's Racial/Ethnic Populations***

May 2008

*Michigan Department
of Community Health*



**Jennifer M. Granholm, Governor
Janet Olszewski, Director**

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Color Me Healthy Profile

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Chapter 1: Introduction

This report marks the inaugural edition of the *Color Me Healthy Profile of Michigan's Racial/Ethnic Populations*. The purpose of this document is to highlight the **health** of minority populations and document the **disparities** that exist. Through empowering communities, local and state entities, we will be one step closer to our pursuit to eliminate racial/ethnic disparities in health across the state.

Background

The Michigan Department of Community Health has had a long-standing commitment to improve the health of all of the state's residents. In 1988, the Office of Minority Health was established by executive order to serve as the coordinating body for minority health issues in the state of Michigan.

In 2004, the Michigan Department of Community Health chose to take a more focused approach towards dealing with minority health, thus creating the Health Disparities Reduction and Minority Health Section. This section was established to provide a persistent and continuing focus on eliminating disparities in the health status of Michigan's at-risk populations of color. The Section primarily serves five populations of color:

- 1) **African Americans/Blacks**
- 2) **Hispanic/Latino Americans**
- 3) **Native Americans/ Alaskan Natives**
- 4) **Asian Americans/ Pacific Islanders**
- 5) **Arab Ancestry**

In addition, the Section chose to focus on six major health areas having the greatest impact on these populations:

- 1) **Cardiovascular Disease**
- 2) **Diabetes**
- 3) **Cancer**
- 4) **HIV/AIDS**
- 5) **Infant mortality**
- 6) **Violence**

This list was compiled through analysis of racial and ethnic data for the state, including *US Healthy People 2010* goals, *Healthy Michigan 2010* goals, the *Michigan Surgeon General's Prescription for a Healthier Michigan*.

The Health Disparities Reduction and Minority Health Section is responsible for the development, promotion, and administration of health promotion

and disease prevention activities for Michigan's populations of color. This responsibility is carried out primarily through grants to local health departments and community-based organizations. The grants currently cover an array of health conditions and are being implemented in communities of color across the state. For more information on the Minority Health section grants, please visit: www.michigan.gov/minorityhealth.

Reducing the disparities that exist in the health and health care of Michigan's minorities is one of the strategic priorities of the Michigan Department of Community Health. According to the Agency for Healthcare Research and Quality's (AHRQ) *National Healthcare Disparities Report*, there are three key themes that have emerged as a result of continuing efforts to reduce disparities:

- 1) **Disparities are pervasive and occur across the many facets of public health**
- 2) **Improvement is possible**
- 3) **Gaps in information exist, especially for specific populations and conditions**

"The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death."

~Guiding Principles for Improving Minority Health

Why is Minority Health Important?

For the last several decades, major advances in the fields of medicine, science and public health, have resulted in increased life expectancy and overall health for all citizens. However, minority residents across the country and in Michigan have not benefited to the same extent from these advances as the white population.

Racial and ethnic minorities suffer disproportionately higher morbidity and mortality rates for several of the diseases and conditions that make up the top ten causes of death. For example, African Americans account for 20% of the deaths due to heart disease, yet only make up 14% of the population in Michigan.^{1,2} African American babies are three times more likely to die in the first year of life than white babies.² American Indians/Alaskan Natives have the highest **death rates** for diabetes and chronic lower

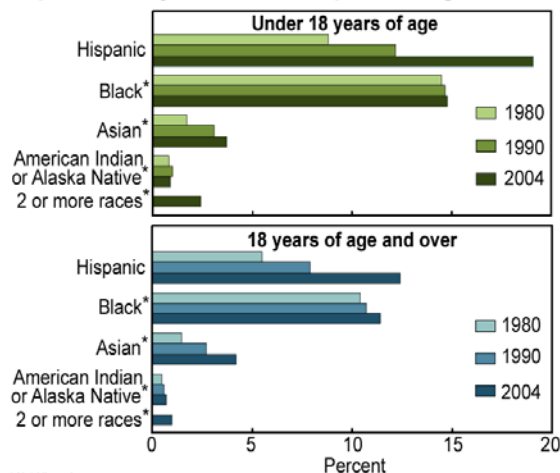
Chapter 2: National Profile

The Nation's Health

Over the course of the last decade, the overall health of the nation has improved. Unfortunately, minority populations have not shared in this improved health to the same magnitude as their white counterparts. The national *Healthy People* goal of eliminating disparities by the year 2010 has placed minority health at the forefront of the nation's health agenda. For over a decade now, increased efforts have been underway to characterize and seek ways to reduce disparities. Across the United States, disparities have been documented in both the health status and healthcare of racial and ethnic minorities.

The increase in racial ethnic minorities over the last 20 plus years provides the most compelling argument for the elimination of disparities.

Population by race and Hispanic origin, 2003



SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Health, United States, 2005, figure 3.

It is estimated that by the year 2050, racial and ethnic minorities will comprise more than 50% of the United State's population. Hispanic/Latinos and Asian/Pacific Islanders represent the fastest growing groups. This shift was most evident in 2004, when the Hispanic/Latino population overtook the African American population as the largest racial ethnic minority group in the country.¹ If strides are not taken now to reduce the disparities that exist in the health of these minority groups, there will soon be a large segment of the population with very poor health outcomes.

"In many ways, Americans of all ages and in every race and ethnic group have better health today than a decade ago yet considerable disparities remain. We should commit our nation to eliminate disparities in the next decade, for through prevention we can improve the health of all Americans."

~ Former US Surgeon General Dr. David Satcher

Disparities in Health Outcomes

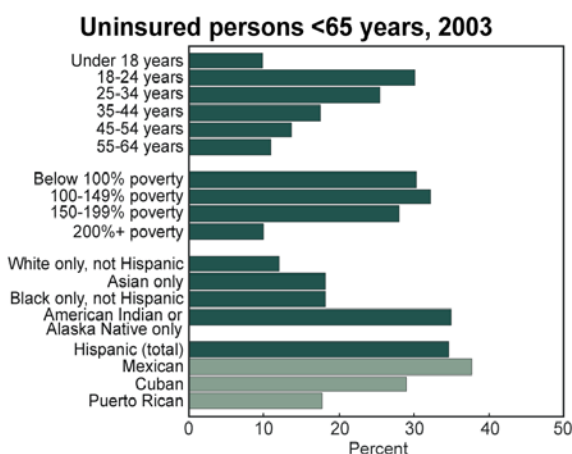
Large disparities exist in cardiovascular health, diabetes, adult immunization rates, infant mortality, asthma, cancer, and other health areas. Hispanic/Latino populations, for example, suffer disproportionately from many of the issues mentioned above. Hispanic/Latinos are two times more likely to die from diabetes than whites. They also suffer disproportionately from tuberculosis, accounting for nearly ten percent of the total deaths. Not only do disparities exist between Hispanics and Whites, they also exist within the Hispanic population. For example, Puerto Ricans have much higher rates of asthma and conditions such as low birth rate that populations classified as Hispanic.

Examining the health status of the African American population, the gaps are even more alarming. If we eliminated disparities experienced by African Americans in the year 2000, there would have been 85,000 fewer deaths among African Americans nationally. This figure includes 4,700 fewer infant deaths, 22,000 fewer deaths from diabetes, 24,000 fewer cardiovascular disease deaths, and 2,000 fewer deaths from breast cancer. African Americans also suffer disproportionately from the effects of violence where an African American is six times more likely to commit a homicide than a white person.⁵

Disparities also exist in the risk factors contributing to mortality. For example, over 34% of the African American adults have been told that they have high blood pressure, in comparison to 26% of the white adults. In addition to high blood pressure; minority populations also have a high prevalence of smoking, obesity and overweight, and lack of physical activity.⁷

Disparities in Healthcare

Across the United States, disparities are also found in access to and quality of care. The national healthcare disparities report ³, released annually since 2003, brought to light many of the healthcare disparities that exist for racial and ethnic populations. One of the issues highlighted in the report, is the percentage of those uninsured. Without insurance, one is less likely to seek and adhere to preventive measures.



Another contribution to disparities is the differential treatment of patients by doctors and the healthcare system. Whether intentional or unintentional, these biases may influence which treatment regimens are recommended. An example may be diabetes, where African Americans have a higher amputation rate than whites.³

Health Outcomes by Race

The table below illustrates the health status of African Americans, Hispanic/Latinos and Whites. The cause-specific percent of total deaths is provided along with the **age-adjusted death rate** for 2004 (most current data available). The **percent change** column can be used to compare the 2004 and 2003 rates, indicating whether the rate increased or decreased. A positive sign (+) indicates that the rate for that cause increased between 2003 and 2004, a negative sign (-) indicates that the death rate decreased from 2003 to 2004. A **disparity rate ratio** was also calculated to compare rates for African Americans to rates for whites and Hispanic/Latinos to whites. For example, those health outcomes where the ratio (Blacks rate/Whites rate, etc) is between 0.0 and 0.9, the rate for Blacks or Hispanics is lower than the rate for whites and the indicator is given a “thumbs up” 👍. If the disparity rate ratio is around 1 (0.9-1.1), the rates are approximately even and the indicator is given a “neutral thumb” 🤔. If the rate ratio is above 1.1, the rate for Blacks or Hispanics is higher than the rate for Whites and the indicator is given “a thumbs down” 👎. The thumbs up/down analysis technique will be used again for in-state comparisons later in the document.

Nationally, rates for African Americans are higher than white rates for six of the top ten causes of death, including the top three causes of death (heart disease, cancer, and stroke). Rates for Hispanics are lower than rates for whites for seven of the top ten causes of death. Rates of deaths due to diabetes are higher than the rate for whites among both African Americans and Hispanics.

Mortality Rate per 100,000 and Rate Ratios by Race, Leading Causes of Death, United States, 2003 - 2004

Disease/Condition	% of total deaths	2004 death rate	% change '03 to '04	Ratio	
				Black to White	Hispanic to White
1. Heart Disease	27.2	222.2	-6.6	👎	👍
2. Malignant Neoplasms (Cancer)	23.1	188.6	-2.3	👎	👍
3. Cerebrovascular Disease (Stroke)	6.3	51.1	-6.5	👎	👍
4. Chronic Lower Respiratory Disease	5.1	41.5	-5.1	👎	👍
5. Accidents (Unintentional Injuries)	4.7	38.1	+1.1	👍	👍
6. Diabetes Mellitus	3.1	24.9	-3.2	👎	👎
7. Alzheimer's Disease	2.8	22.5	+1.9	👍	👍
8. Influenza/Pneumonia	2.5	20.3	-10.0	👎	👎
9. Nephritis (Kidney Disease)	1.8	14.5	-1.4	👎	👎
10. Septicemia	1.4	11.4	-3.4	👎	👍

Source: National Vital Statistics Reports-Final Death Data 2004. Can be found online at:
http://www.cdc.gov/nchs/products/pubs/pubd/hestat/finaldeaths04/finaldeaths04_tables.pdf#4

Chapter 3: State Profile

The State's Health

While the public health has the responsibility of improving the health of all of the state's residents, the state of Michigan has invested interest in improving the health of its minority populations in particular. The figure below compares the disparity trends (i.e., the difference in rates between two groups) for Michigan to those of the United States, using data comparing African Americans and whites.

Disparity Trends- Michigan vs. U.S.^{2,6,7}

Michigan is Better...

*Chronic Lower Respiratory Disease Deaths
Diabetes Mellitus Deaths
Stroke Deaths*

United States is Better....

*AIDS Deaths
Heart Disease Deaths
Homicide
Unintentional Injury Deaths
Cigarette Smoking
Inadequate Physical Activity
Infant Mortality*

Even...

*Cancer Deaths
Adult Immunizations
Obesity*

Demographics

Similar to the trends in population growth seen across the country, the state of Michigan has also seen an explosion of growth amongst its racial and ethnic minorities. Currently, Michigan's minority population comprises over 20% of its total population. Over the past 20 years, the percentage of whites has decreased, while the percentage of all other racial and ethnic groups has increased between 9 and 350%.¹ These data imply that the state of Michigan, like the rest of the country, must make a concerted effort to reduce the health disparities experienced by a large segment of the population.

"We cannot become what we need to be by remaining what we are"

-Max Depre

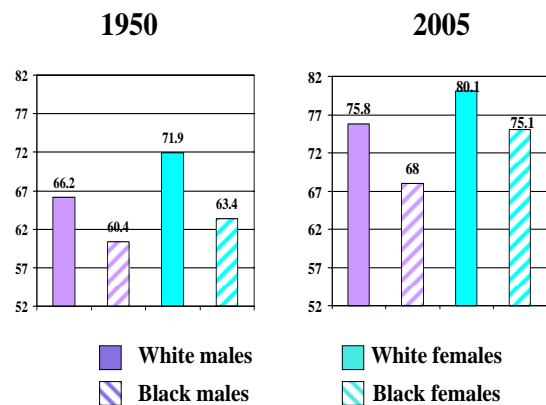
Distribution of Michigan's Population
by Race/Ancstry

Race/Ancstry	1980	1990	2000	2005	% Change
White	85.8	84.2	80.2	80.0	-6.8
Black	13.0	14.0	14.2	14.0	+7.7
American Indian	0.5	0.6	0.6	0.6	+20.0
Asian/Pacific Islander/ Other	0.7	1.2	3.1	3.8	+442.9
Multi-Racial	N.A.	N.A.	1.9	1.6	N.A.
Hispanic	1.7	2.2	3.3	3.8	+123.5

Disparities in Health Status

The state of Michigan has been successful in improving the overall health of the entire population, as evident by the increases in life expectancy over the last 50 years. Unfortunately, not all populations have benefited from these advances to the same extent. The life expectancy of black males in 2005 is very similar to the life expectancy of white males in 1950.² While the health of African American males is improving, in comparison to white males, disparities still persist.

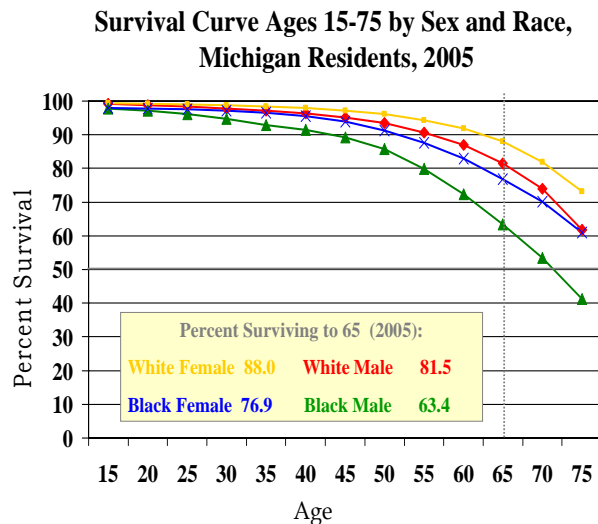
Michigan Life Expectancy



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

The need for improvement in the health of African American males is also evident in rates of survival to different ages (graph below). Over 36% of African American males in Michigan do not live to the age of 65. While improvement in life expectancy has been occurred over time, it has not been to the same extent as other populations. Focus on African American

male health should significantly reduce existing disparities between Michigan's majority and minority populations.



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

Michigan is the home to the second largest population of people of Arab Ancestry outside the Middle East. Many residents of Arab Ancestry reside in Dearborn and surrounding areas. Because of unstable population estimates, age-adjusted death rates could not be calculated for this population and many comparisons made for other groups were not possible. However, providing quality, equitable healthcare to this population has many challenges, such as language barriers and acculturation issues that can contribute to disparities in health outcomes.

Data on Michigan's leading causes of death (see table) provide a snapshot of disparities experienced by racial/ethnic populations. The highest rate for each leading cause of death is bolded and the thumbs up/down mechanism is used to display disparities. For those deaths where the disparity ratio is between 0.0 and 0.9, the group of interest's rate is lower than the rate for whites, and the indicator is given a "thumbs up" 👍. If the disparity rate ratio is approximately even (0.9-1.1), the rates for two groups are similar - this is indicated by a neutral thumb 👉. If the ratio is above 1.1, the rate for the group of interest is higher than the white rate, and the indicator is given a "thumbs down" 👎.

Whites have the highest mortality rates for Alzheimer's disease and suicide. African Americans, in addition to having the highest overall mortality rate, have the highest rates for heart disease, cancer, influenza/pneumonia and kidney disease. American Indian populations have the highest rates for all other causes of death presented.

While the task at hand is large, the state has the ability to reduce disparities. This report's purpose is to raise awareness of health status of the State's minority populations. The remainder will address the health status and disparities that exist amongst each of the five populations of color.

Mortality Rates per 100,000 and Ratios for Leading Causes of Michigan Deaths, by Race 2005

	White	African American	American Indian/ Alaskan Native	Asian/ Pacific Islander	Hispanic/ Latino
Deaths	Rate	Rate	Rate Ratio	Rate	Rate Ratio
Overall	775.5	1045.4	👎	923.8	👎
Heart Disease	219.0	322.7	👎	198.5	👎
Cancer	186.3	225.7	👎	214.3	👎
Stroke	44.2	61.6	👎	62.4	👎
CLRD	43.9	28.1	👍	64.2	👎
Unintentional Injury	32.7	33.4	👉	34.9	👎
Diabetes Mellitus	24.7	40.0	👎	48.2	👎
Alzheimer's Disease	23.0	11.1	👍	*	NA
Pneumonia/ Influenza	18.0	19.2	👎	*	NA
Kidney Disease	13.8	29.4	👎	*	NA
Suicide	11.7	5.8	👍	*	NA

Source: Vital Records & Health Data Development Section, Michigan Department of Community Health; NA: Rate does not meet standards of or reliability; CLRD: Chronic Lower Respiratory Disease; Bolded numbers indicate rate that is highest for the specified disease category

Chapter 4: African Americans or Blacks



Blacks or African Americans are people living in the United States having origins in any of the black racial groups of Africa.¹³ As of 2005, African Americans made up the state of Michigan's second largest racial/ethnic group comprising about 14% of the overall population.¹ The majority of Michigan's African Americans reside in urban communities. The city of Detroit is home to the largest population of African Americans, with 80% of the city identifying as such.¹ Areas outside of southeast Michigan with an increased presence of African Americans include the cities of Grand Rapids, Flint, Saginaw, Lansing, Kalamazoo, and Benton Harbor.

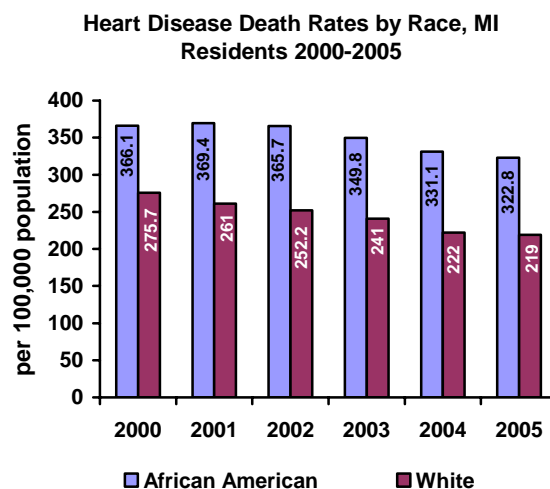
African Americans are one group for which disparities in health outcomes are high. While genetics and personal health choices such as exercise and diet are contributing factors, as mentioned earlier, social factors and access to health care also play a significant role. In the state of Michigan, 19.1% of the African American population has less than a high school education (13% of whites), 10.8% of the African American labor workforce is unemployed (5.8% of whites), 19.6% of African Americans lack health insurance (11.3% of whites), and 29.9% are living in poverty (9.9% of whites).¹ Improvement in the health status and outcomes of African Americans and other populations of color will require an integrated approach from all parties involved. Isolating focus solely on health and healthcare outcomes will not produce long standing results; partnerships between the community, private entities, and policy makers will be essential to fostering change.

<u>Top 5 Causes of Death</u>	<u>% of Deaths</u>
1. Heart Disease	29%
2. Cancer	21%
3. Stroke	6%
4. Diabetes Mellitus	4%
5. Unintentional Injury	4%

African Americans are disproportionately impacted by nearly every condition leading to the top 10 causes of death. For purposes of this document, the first 5 will be discussed in detail with additional diseases of interest explored at the end of the chapter.

1. Heart Disease

Heart Disease is the leading cause of death for African Americans, and one of the main contributing causes of cardiovascular disease death.



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

Disparities in rates of heart disease mortality are very striking for this population. African Americans are 50% more likely to die from heart disease than whites. The disparity that exists between the two races has increased each year from 2000 to 2005. While heart disease is the leading cause of death for all populations, heart disease appears to occur earlier in life for African American males, thus causing a significantly higher rate of potential years of life lost for this population (1,582.8 per 100,000 population in comparison to 539.2 per 100,000 population for white males).²

2. Stroke

Stroke rates also depict the disparity that exists in health status for African Americans. The stroke mortality rate for African Americans is 63.3, in comparison to the mortality rate for whites, which is 47.7, a 1.3 fold difference. Stroke, also appears to impact African Americans earlier in life, causing higher rates of potential years of life lost. African American males have a rate nearly 3 times that of

white males, and African American females have a rate 2.6 times that of white females.²

3. Cancer

With the exception of breast cancer, the rates of cancer diagnosis are higher for African Americans for all cancer sites routinely monitored by public health: colorectal, lung, cervical, and prostate. For example, the incidence rate for prostate cancer among African Americans is twice the rate for whites. Mortality rates are higher for African Americans than whites for all 5 of the “public health” cancers previously mentioned including breast cancer. Analysis by cancer location and stage of disease show that African Americans are more likely to be diagnosed with cancer once it has reached a later stage of disease. This suggests that not only are African Americans impacted greater by the disease, but they are getting into care later.²

Many cancers, such as cervical and breast, have better outcomes with early detection. This is of particular concern when referring to breast cancer because, although white women are more likely to get breast cancer, African American women are more likely to die from it. The overall cancer mortality rate for African Americans is 225.7 per 100,000 populations, whereas, the cancer mortality rate for whites is 186.3 per 100,000 populations, meaning an African American is over 20% more likely to die from cancer than a white person.²

4. Diabetes

Diabetes is a disease that is widely known throughout the African American community as “sugar”. This disease impacts this community at a higher rate than it impacts most other racial/ethnic communities. Approximately 11% of African Americans living in the state of Michigan have this disease, compared to only 7% of the white population.

Diabetes mortality rates are also high for this population. The death rate for diabetes amongst African Americans is 42.5 per 100,000, in comparison to the rate amongst whites of 26.3 per 100,000 populations.² In other words, African Americans are 60% more likely to die from diabetes than whites. As to the potential complications of diabetes, African Americans account for 34% of all people with kidney disease and 46% of all people on kidney dialysis, although they make up only 14% of the population.⁸

5. Unintentional Injury

Unintentional injury is one category of deaths that often goes unnoticed by the general public, yet, for the African American community, causes a significant number of deaths. Motor vehicle crashes are the most common cause of unintentional injury, but additional causes include, but are not limited to: fires, drownings, poisonings and

suffocation. In 2005, the African American death rate from unintentional injury was 33.4 per 100,000 population. This was very similar to the death rate from unintentional injury amongst whites at 32.7 per 100,000.² While death is the most adverse health outcome, additional impacts of unintentional injury can result in hospitalization or long-term physical/mental impairments.

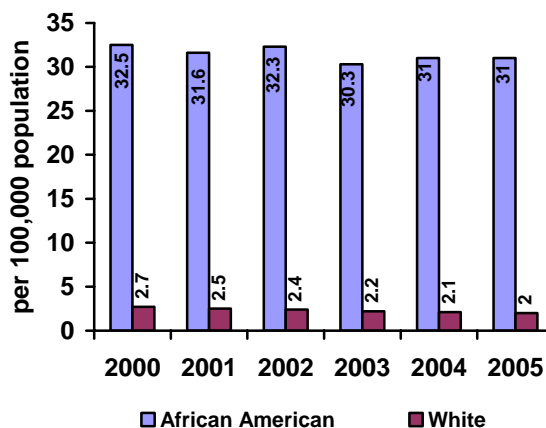
In addition to the top 5 causes of death, there are three diseases/conditions that are of particular concern in the African American community. While homicide, infant mortality and HIV/AIDS do not cause high numbers of deaths, the disparities seen between African Americans and whites are significant.

Homicide

The homicide rates for African Americans living in the state of Michigan are 15.5 times that of whites. African Americans have a homicide rate of 31.0 per 100,000 populations, and whites have a homicide rate of 2.0 per 100,000 populations.²

The disparity is even greater for African American males. African American males have a homicide rate of 56.8 and white males a homicide rate of 2.4, meaning that the African American male rate is over 23 times as high as the white rate. The rate is highest for African American males between the ages of 15 and 24.²

**Homicide Death Rates by Race, MI Residents
2000-2005**



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

The data for African American women indicates that the homicide rate for this population is over 5 times higher than the rate for white women.²

The overall and gender specific homicide rates among African Americans in Michigan are higher than the African

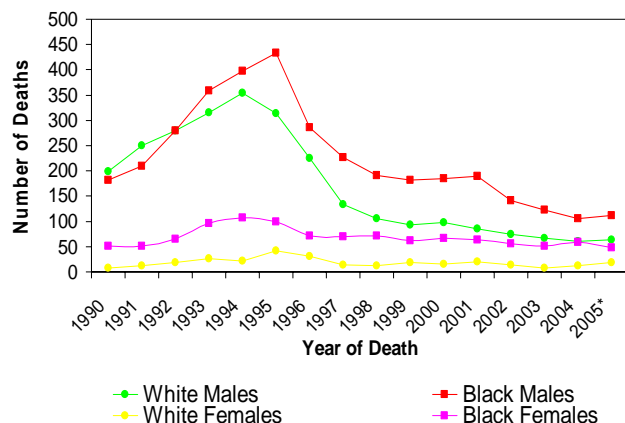
American homicide rates for the US. This extremely high homicide rate may be the result of several issues including poverty, unemployment, lack of hope, access to guns, alcohol and drugs and mental disease.⁹ The devastating effects of homicide are made even clearer when looking at the potential years of life lost. While homicide does not make the top 5 causes of death for African American men, it has the second highest rate of years of potential life lost; this rate is 25 times higher than the homicide rate in white men.²

HIV/AIDS

HIV/AIDS also affects African Americans at a much higher rate than other populations. In fact, while the overall number of deaths from AIDS is decreasing, the death rate from AIDS is over eight times higher in the African American population than it is in the white population.²

Not only is death high in this population, but the number of people living with HIV/AIDS is high as well. African American males have the highest number and rate of AIDS cases in the state, and African American women have the third highest number of cases and the second highest rate of infection.²

HIV Related Deaths in Michigan, all ages, by Race & Sex, 1990-2005



Source: Michigan Department of Community Health, Bureau of Epidemiology/HIV/AIDS Surveillance Program

Geographically, there are areas of high and low HIV prevalence. However, African Americans are more likely to acquire HIV than whites in both the high and low prevalence areas.¹⁰

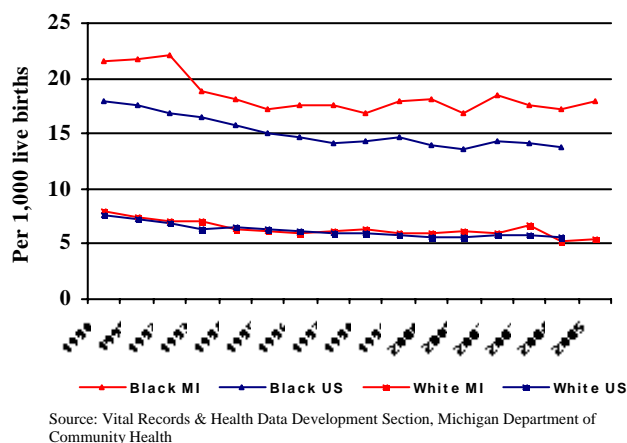
AIDS is another cause of death in which the rate of potential years of life lost for African Americans is much greater than that for whites. The rate of potential life lost for African American males is over 9 times the rate in white males, and the rates for women are just as staggering.²



Infant Mortality

The infant mortality rate in the state of Michigan is higher than the overall rate for the US, and the rate amongst African Americans is also higher than the US African American rate, as well. The high rates of infant mortality in the state of Michigan can be attributed, for the most part, to the high rates of infant mortality in African Americans. An African American baby is over 3 times more likely to die in the first year than a white baby (the rates are 17.9 deaths per 1,000 live births for African Americans, and 5.5 deaths per 1,000 live births for whites). The disparity between blacks and whites declined slightly between 2004 and 2005, but the infant mortality rate for both populations increased.²

Infant Mortality Rate by Race, MI 1990-2005



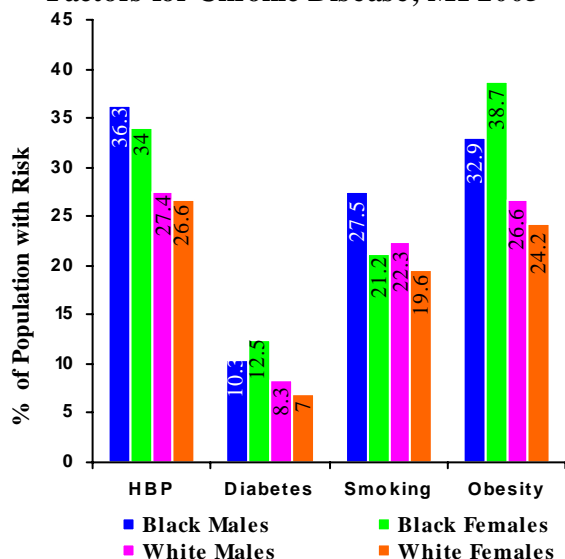
Thorough analysis of infant mortality in the African American community reveals two emerging themes. The majority of deaths occur among babies born with a low birth weight (under 1,500 grams), indicating a maternal health/prematurity issue. A significant proportion, are also attributed to babies born weighing more than 1,500 grams, who die in the first month of life, indicating an infant health concern.¹¹

Risk Factors

Aside from the diseases themselves, disparities also exist in the risk factors that lead to these diseases. Looking at high blood pressure, smoking, obesity and lack of physical activity, we begin to see the foundation that is laid for the differences in disease outcomes seen further down the line. Among adults, nearly 40% of African Americans have high blood pressure, while only 27% of whites have it. Nearly 24% of African Americans reported that they were current smokers, in comparison with 21% of whites. This

result was particularly interesting because Chronic Lower Respiratory Disease (chronic obstructive pulmonary disease, emphysema, chronic bronchitis, etc.), which is directly correlated with smoking, is actually significantly lower in the African American population than in whites. The contributions of obesity and overweight to poor health have become more commonly noticed over the last several years. Over 36% of African Americans identified as obese, in comparison to 25.4% of whites. And if looking at the percentage of the population getting inadequate physical activity, we see that 58.4% of African Americans have this problem, and 48.7% of whites.⁶

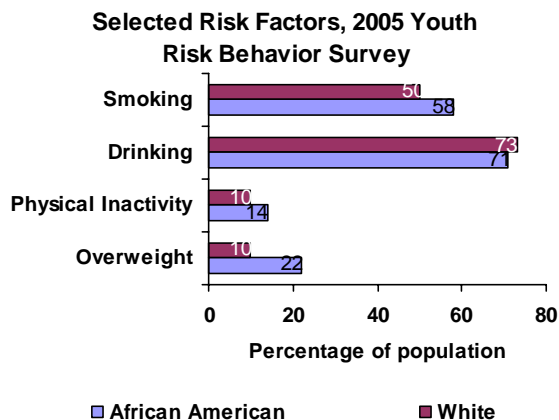
Racial and Gender Disparities in Risk Factors for Chronic Disease, MI 2005



Source: Michigan Behavior Risk Factor Surveillance System

Selected risk factors for adolescents were also discouraging.

The next chart provides percentages of high school students reporting have ever tried smoking, ever tried alcohol, lacking physical activity in the last 7 days, and being classified as overweight. Immediately, some striking differences by race are evident, smoking and drinking are high for both populations, however, physical inactivity is 20% higher for African Americans as Whites, and more than twice as many African Americans reported being overweight in comparison to whites.¹²



Source: Michigan Youth Risk Behavior Surveillance System

Years of Potential Life Lost

Another way to grasp the impact of disease on African Americans is to look at the years of potential life lost. The total years of potential life lost also displays significant disparities. The rate of years potential life lost for all causes in African American males is 14,923.0, which is nearly (1.9) 2 times the rate for white males at 7,914.8. The rate of years potential life lost for all causes in African American women is 9,572.0 which is 2 times the rate for white females at 4,872.8. The years of life lost to CLRD are higher in African Americans, than in whites. Yet, whites have higher overall death rates, indicating that the disease impacts African Americans earlier in life.² These data further displays that a number of African Americans are disproportionately impacted by disease at an earlier age.

Positive Signs

There are several positive aspects of African American health that the state of Michigan can build upon, and work towards creating a healthier community, free of inequities.

✓ To date strides have been made to reduce the overall mortality rates and increase the life expectancy, both of which have been successful. Trends in life expectancy for African Americans indicate that life expectancy has continued to increase over the past 5 years, while the overall mortality rates for this population continue to decline.

✓ Decreasing trends in death rates over the past 5 years have been seen for Heart Disease, AIDS, Cancer, Chronic Liver Disease, Septicemia, and Stroke.

✓ While, insurance coverage is lower in the African American community, more African Americans than whites, reported having an annual check-up in the last year.

Chapter 5: Hispanic/Latinos



Hispanics or Latinos are persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.¹³ The federal government and the state of Michigan consider race and Hispanic origin to be two separate categories; Hispanic/Latinos may be any race. Hispanic/Latinos make up the state of Michigan's third largest racial/ethnic population, comprising just under 4% of the population (3.8%).¹ The actual population of Hispanic/Latino Americans fluctuates throughout the year because of the large migrant farming population in Michigan. The Detroit and Grand Rapids areas are home to the largest communities of this racial/ethnic group.

The majority of Michigan's Hispanic/Latino population is of Mexican descent, including a large migrant farm population. While health-related factors play a large role in overall health outcomes, this should not diminish the importance of investigating the social problems and lack of access faced by this population. Compared to the White population in Michigan, the Hispanic/Latino population is more likely to have less than a high school education (35.4% of Hispanic/Latinos vs. 13% of whites), to be unemployed (9% of the Hispanic/Latinos in the labor workforce vs. 5.8% of whites), lack health insurance (32.7% vs. 11.3%), and live in poverty (20.9% vs. 9.9%). More than one-half (57%) of this population speaks a language other than English at home, with 28.6% speaking English less than well.¹

Although age-adjusted death rates for four of the five leading causes of death are lower for Hispanic/Latinos than for whites, the health status of this population is still of significant concern.

<i>Top 5 Causes of Death</i>	<i>% of Deaths</i>
1. <i>Heart Disease</i>	21%
2. <i>Cancer</i>	17%
3. <i>Stroke</i>	5%
4. <i>Diabetes Mellitus</i>	5%
5. <i>Unintentional Injury</i>	9%

1. Heart Disease

In 2005, heart disease accounted for 21% of all deaths in the Hispanic/Latino population. The death rate for this population has declined since 2003. The heart disease death rate in 2005 was 158.9 per 100,000 populations, in comparison to the rate of amongst whites of 219.0 per 100,000 populations.² Heart disease death rates remained consistently lower than rates for whites between 2000 and 2005.

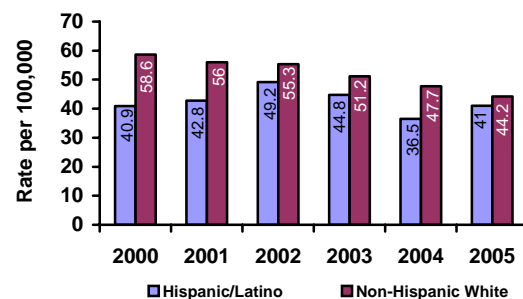
2. Cancer

Seventeen percent of total deaths in this population are attributable to cancer. Cancer has been the second leading cause of death for this population since 2000 and rates increased from 2000 to 2005. Cancer rates for Hispanic/Latinos were significantly lower than whites during this period. White rates were anywhere from 1.3 times to 1.6 times higher than rates for Hispanic/Latinos.²

3. Stroke

Stroke death rates for the Hispanic/Latino population in Michigan remained lower than the white population from 2000 to 2005 as well.²

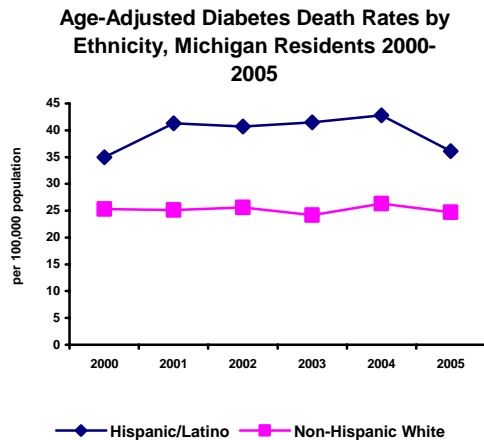
Age-Adjusted Stroke Death Rates by Ethnicity, Michigan, 2000-2005



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

4. Diabetes

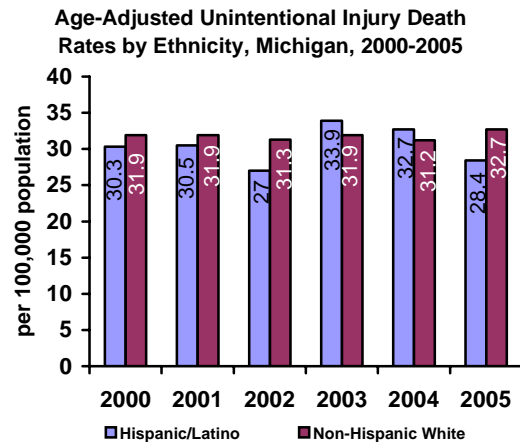
Diabetes is one disease that impacts Hispanic/Latinos to nearly the same extent as it impacts African Americans. Diabetes accounts for 5% of total deaths in this population. According to 2005 estimates, 8.5% of Hispanic/Latino adults have diabetes; compared to 7.6% of whites.⁶ Death rates due to diabetes were 50% higher among Hispanic/Latinos (36.12 per 100,000) than rates for whites. The death rate was also higher than those for American Indian/Alaskan Natives (48.2) and African Americans (40.0).²



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

5. Unintentional Injury

Unintentional injuries accounted for 9% of overall deaths in this population, almost double the proportion of injury deaths found in the general population (4%). This may seem counterintuitive as injury is only the fifth cause of death. However, death rates are age-adjusted in order to make comparisons between groups. The relatively lower rate compared to the high percentage of all deaths is because the Hispanic population is much younger than the white population in Michigan, and unintentional injury deaths occur more frequently in younger people. The death rate from unintentional injuries in 2005 was 28.4 per 100,000 population. The rate for Latino/Hispanics continued to remain close to the rate for whites between 2000 and 2005.²

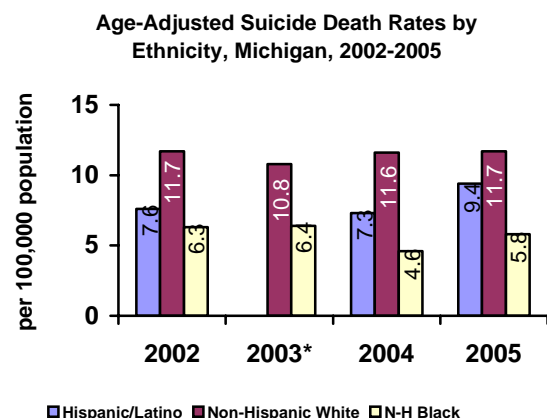


Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

Aside from the top five causes of death, three other diseases/conditions of particular interest in the Hispanic/Latino population are highlighted here.

Suicide

Suicide is emerging as a particular concern in the Hispanic/Latino population. The suicide rate in this group is the second highest of all racial/ethnic populations, second only to whites. The suicide death rate in this population in 2005 was 9.4 per 100,000 population, compared with 11.7 for whites and 5.8 for African Americans.² For the years 2000, 2001 and 2003 data for this Hispanic/Latinos did not meet the standards for precision or reliability and thus were not included for analysis.



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health. * Hispanic/Latino rate not available for 2003

HIV/AIDS

Hispanic/Latino males have the third highest **rate** of HIV/AIDS cases at 300 per 100,000 population and the fifth highest **number** of HIV/AIDS cases of all racial/ethnic groups. In comparison, white males have the fourth highest rate (137 per 100,000) and the

second highest number. Similarly, Hispanic/Latino females have the fifth highest rate of HIV/AIDS cases (170 per 100,000 population) and the sixth highest estimated number of HIV/AIDS cases. White females have the lowest rate of any group (20 per 100,000) and the fourth highest number.¹⁰ These data illustrate the increasing impact of HIV/AIDS on the Hispanic/Latino population in Michigan. Despite comprising just over 3% of the population, Hispanic/Latinos account for 4% of the HIV/AIDS cases.¹⁰

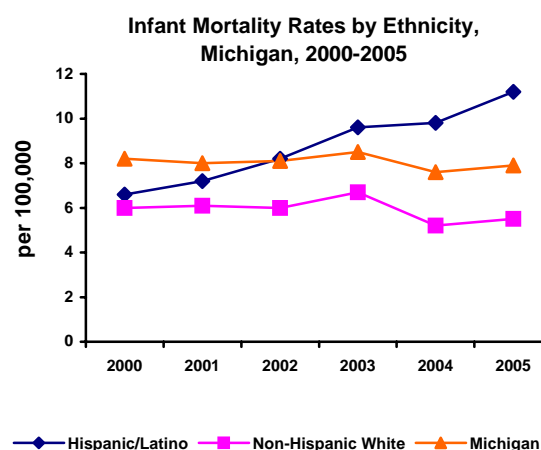
If we look at HIV/AIDS by geographic location, the areas of the state with the highest Hispanic/Latino case rates are found along the Lake Michigan shoreline, or slightly to the east of it. This pattern is most likely due to the large population of migrant workers that rotate through this area.¹⁰ While case rates are higher on the west side of the state, Detroit and surrounding areas continue to have the largest number of cases (due to the larger population there. Finally, case rates are two to three times higher for Latino/Hispanic Americans than for whites in all geographic areas; regardless of the underlying prevalence of an area.¹⁰



Infant Mortality

The infant mortality rate for Hispanic/Latinos is two times higher than the infant mortality rate for whites. In addition, the gap between rates for Hispanic/Latinos and whites has been increasing over the past 5 years. In 2000, the infant

mortality rate for Hispanic/Latinos was 1.1 times that of whites, in comparison with the current rate, which is 1.8 times that of whites (11.2 per 1,000 live births for Hispanic/Latinos and 5.5 per 1,000 live births for whites in 2005).² The increase in disparity is due to the dramatic increase in infant mortality rates for Hispanic/Latino population during the time period.

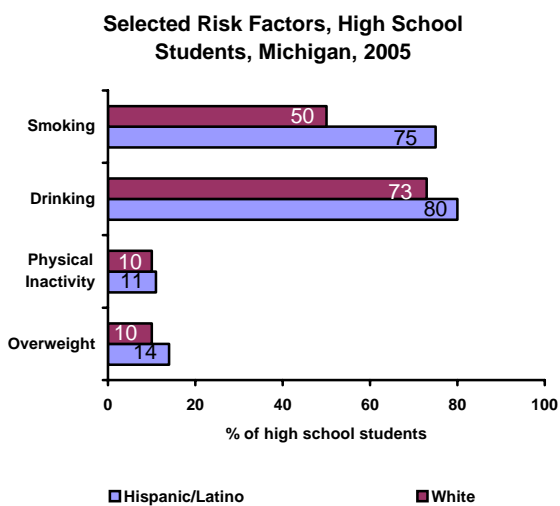


Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

Risk Factors

Not only are Hispanic/Latino residents of the state of Michigan more likely to die from certain diseases, in several cases, they are also more likely to have higher rates of the risk factors that lead to those diseases. Nearly 24% of Hispanic/Latino adults reported ever having been told that they have high blood pressure. In addition to this, 28.4% reported being a current smoker, 24.4% were currently obese, and 57.2% indicated they get inadequate physical activity. In addition to these risk factors, 35.4% of the Hispanic/Latino adults reported that they had no routine check up in the past year.⁶

Many times, health behaviors are learned over time starting early in life. Using data from the Michigan Youth Risk Factor Survey, a glimpse of potential habit forming trends can be assessed.



Source: Michigan Youth Risk Behavior Surveillance System

The graph on the previous page displays the percent of high school students who have ever tried smoking, ever tried alcohol, received no physical inactivity in the past seven days, and who reported height and weight that indicated they were overweight. Clear themes begin to emerge about the Hispanic adolescent population. The majority of students reported drinking and smoking. The percent of students having tried alcohol was high among all racial and ethnic groups, however the percent of Hispanic/Latino students having tried smoking was 1.5 times that of the white student population. The percent of Hispanic/Latino high school students reporting overweight was 40% higher than the percent reported for white high school students. The percent of students lacking physical activity in the previous seven days was pretty consistent between Hispanic/Latinos and whites.¹²

Positive Signs

There are several positive aspects to the health of this population that are encouraging.

✓ The death rates for four of the five leading causes of death are lower than the death rates for the white population.

✓ Decreases were seen in the death rates for three of the five leading causes of death (heart disease, cancer, and unintentional injuries).

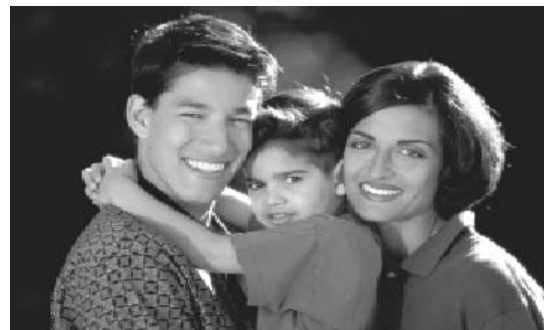
✓ While, healthcare coverage is significantly lower for Hispanic/Latinos, the percentage of the population who had a checkup in the past year was higher among this group than among whites.

By increasing the awareness of the disparities faced by this growing population, the state is taking measures to increase prevention and treatment options targeted at this population throughout the state.

The Health of Migrant Populations

Migrant and seasonal farm workers contribute a significant amount to the economy of the state. A seasonal farm worker is defined as one whose principal employment within the last two years has been agricultural and on a seasonal basis; whereas, a migrant worker is defined similarly, but establishes a temporary living arrangement for the purposes of such employment. According to a survey of migrant and farm workers recently released by the state of Michigan, there are 90,716 migrant and seasonal farm workers and non-farm workers in the state. There are several health concerns impacting this population. Many of these problems arise because of barriers facing migrant and seasonal farm workers when accessing primary and preventive services. Some of these barriers include: the lack of bilingual services, work hours not accommodating to the typical farm work day, lack of health insurance, and cultural prejudices. Below are just a few examples of the poor health of this population:¹⁴

- Migrant and seasonal farm workers suffer disproportionately from infectious diseases.
- Of those visiting migrant health clinics, more than 40% have multiple and complex health conditions.
- Diabetes and hypertension emerge as common problems for both males and females.
- Over 50% of migrant/ farm worker patients have digestive system problems, and over 50% suffer from respiratory system diseases.



Chapter 6: American Indians/Alaskan Natives



American Indians and Alaskan Natives (AI/ANs) are people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.¹³ The AI/AN population in the state of Michigan is small, comprising 0.6% of the total population.¹ The Upper Peninsula and the northern part of the Lower Peninsula are

home to the largest population of American Indian/Alaskan Natives in the state.

2005 rates for education, insurance coverage and employment could not always be calculated for American Indians/Alaskan Natives in the state of Michigan due to small population size. However, according to year 2000 census estimates, 23.6% of the population has less than a high school education (13% of whites) and 10.3% of the population is unemployed (5.8% of whites). National data was used to assess insurance coverage with more than one third (35%) of AI/ANs lacking health insurance.¹

<i>Top 5 Causes of Death</i>	<i>% of Deaths</i>
1. Cancer	23%
2. Heart Disease	20%
3. CLRD*	6%
4. Stroke	6%
5. Diabetes	5%

*CLRD - Chronic Lower Respiratory Disease

American Indians/Alaskan Natives have some of the highest mortality rates of all racial/ethnic groups. The top five causes of death differ from the general population, in particular in order of cancer and chronic lower respiratory disease deaths (CLRD).

1. Cancer

American Indians/Alaskan Natives have high incidence and death rates for cancer. In fact, they have the second highest death rate of racial/ethnic groups due to cancer, 214.3 per 100,000, which is only slightly lower than the rate for African Americans, and 20% higher than the rate for whites.² The tables below provide the rates for cancer incidence and deaths by type.

Age-Adjusted Death Rates per 100,000 for Select Primary Sites, American Indian/Alaskan Natives, Michigan 2000-2004

Primary Site	Total	Male	Female
Colon/Rectum	23.0	25.8	21.0
Lung	88.0	105.5	76.9
Breast			25.8

Age-Adjusted Incidence Rates per 100,000 for Select Primary Sites, American Indian/Alaskan Natives, Michigan 2000-2003

Primary Site	Total	Male	Female
Colon/Rectum	24.1	22.4	23.8
Lung	47.2	55.9	41.3
Breast			35.0
Prostate		39.7	

Source: 2000-2004 Michigan Resident Death Files, Michigan Department of Community Health, Vital Records and Health Development Section

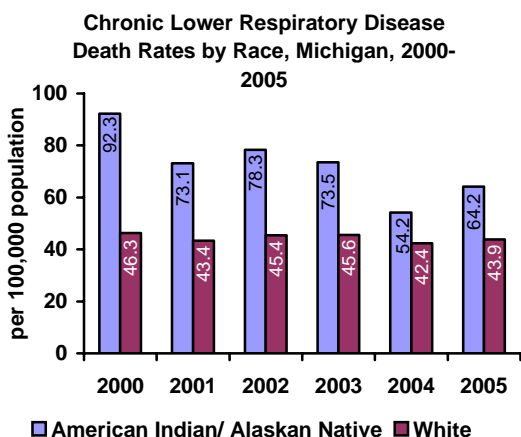
2. Heart Disease

Heart Disease, the major component of cardiovascular disease, adversely impacts the American Indian/Alaskan Native population. Heart disease accounted for 20% of the total deaths in 2005. The death rate due to heart disease was 198.5 per 100,000 persons, the third highest rate of all racial/ethnic groups (219 for whites).²

3. Chronic Lower Respiratory Disease

CLRD is the third leading cause of death for this population, having a death rate of 64.2 per 100,000 persons. The CLRD death rate is higher for this population than it is for any other racial/ethnic

population in the state. The rate is 50% higher than the rate of whites, the second highest group.



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

4. Stroke

2005 marked the first year that age-adjusted stroke death rates could be calculated. In 2005, the AI/AN population had the highest stroke death rate of all racial/ethnic groups. The stroke death rate in this population is 62.4 per 100,000 populations, compared to 44.2 per 100,000 population for whites.²

5. Diabetes

Diabetes continues to be a significant challenge in the American Indian/Alaskan Native population. It is estimated that as many as 8.6% of adults has diabetes, this is in comparison to 7.6% of white adults.⁶ From 2000 to 2005, the diabetes death rates for this population have continued to be the highest of any racial/ethnic population in the state. In 2005, the diabetes death rate in the American Indian/Alaskan Native population was 1.5 times that of whites.²

The top five causes of death contributed to the majority of mortality seen in this population, however, there was one other cause of death that should be mentioned for American Indians/Alaskan Natives.



Unintentional Injury

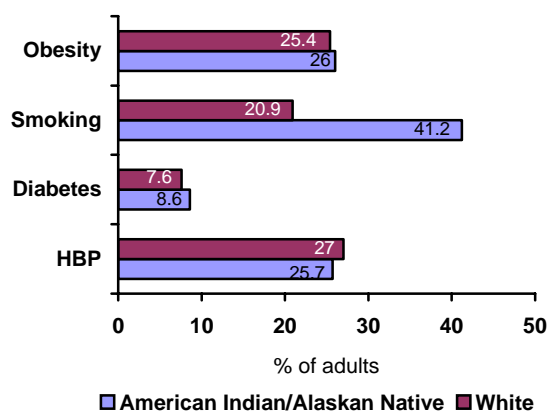
Unintentional Injury is another cause of death for which the American Indian/Alaskan Native population has continued to have higher death than all other populations. In 2005, the cause specific death rate for this

population was 34.9 per 100,000, in comparison to 33.4 for African Americans and 32.7 for whites.²

Risk Factors

Not only are American Indians/ Alaskan Natives disproportionately impacted by the diseases mentioned above, they also suffer disproportionately from many of the risk factors for these diseases. Take for instance, high blood pressure. Over 25% of the American Indian/Alaskan Native adults reported being told that they have high blood pressure. Over 40% of adults currently smoke, 7% reported getting inadequate physical activity, and 26% reported being obese.⁶

**Proportion of Adults with Risk Factors for
Chronic Disease, by Race, Michigan, 2005**



Source: 2005 Michigan Behavioral Risk Factor Survey

Adults are not the only population that has disproportionately high percentages of selected risk factors. In a survey of Michigan high school students, 71% of American Indian/Alaskan Natives reported having tried cigarettes (in comparison to 50% of white students), 78% reported having tried alcohol (73% of whites), 16% of students reported that they were overweight (10% of whites). One promising fact is that 96% of high school students reported having some form of physical activity in the last seven days.¹²

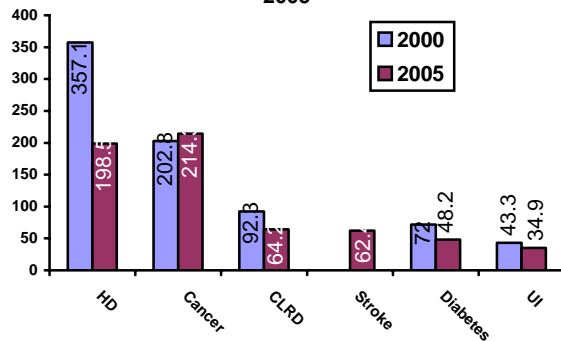
Positive Signs

While the overall and disease specific mortality rates are high for this population, for many of the leading causes of death, the rates are considerably lower than they were in 2000.

✓ Heart death rates saw a drastic decline (44.4% decrease) from 2000 to 2005.

✓ Diabetes death rates declined over 33% from 2000 to 2005.

Selected Mortality Rates for American Indian/Alaskan Natives, Michigan 2000 & 2005



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

The American Indian/Alaskan Native population is unique in that it has a healthcare system designed to take care of the needs of the community. Nationally, approximately 55% of the AI/AN population relies on these services, which are provided mostly in the Western United States and Alaska. In trying to account for the disparities experienced by this population, health care experts, tribal leaders, and policy makers are looking at the factors impacting the health of the American Indian/Alaskan Native population, which includes the adequate funding of the Indian Healthcare Delivery System.²⁴

Indian Health Service

Based on treaty obligations and federal statutes, the U.S. government has a trust responsibility to provide health care to members of the federally recognized tribes. The Department of Health and Human Services has fulfilled that trust since 1955 through what is known as Indian Health Services (IHS). The IHS is the principle Federal health care provider and health advocate for Indian people. IHS is divided up into three areas, often referred to as the I/T/U system:

- IHS direct healthcare services- health centers and hospitals managed through
- Tribally-operated health care services,
- Urban Indian health care services and resource centers.

The IHS provides a health system that is comprehensive in delivery of services, and yet maximizes Tribal involvement in developing and managing programs to help meet the identified health needs.

IHS pays for the health services of:

- Members of 561 federally recognized Tribes in 35 states
- 1.9 million AI/ANs residing near or on reservations
- 600,000 American Indians in urban clinics

The total budget for IHS expenditures is \$3.1 billion.

Not only are treatment options included in IHS services, but prevention is covered also. Educational, environmental, and outreach prevention measures are combined with therapeutic measures to make a total healthcare system. IHS services are provided directly and indirectly, with health services also including care purchased from private providers.¹⁵

“The elimination of health disparities is an important step in accomplishing the mission of the Indian Health Service – to raise the health status of American Indian and Alaska Native people.”

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director, Indian Health Service²⁴

Chapter 7: Asian/Pacific Islanders



Asian Americans are people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. Native Hawaiian and other Pacific Islanders are people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.¹³

The two groups are combined due to the small numbers of the Pacific Islanders in Michigan (3,546 people).¹ The Asian/Pacific Islander population is Michigan's fastest growing racial/ethnic group and is the fourth largest racial/ethnic group (2.3% of population).¹ Compared to whites, Asians are equally likely to have less than a high school education (12.9% vs 13% for whites), be unemployed (4.4% vs 5.8%), or live in poverty (13.8% vs. 9.9%). Cambodians, Laoatons, and Hmongs have lower economic stability, increasing the risk of unfavorable health outcomes. Lack of health insurance is a concern for Asians and Pacific Islanders: 17.9% of has no health insurance (11.3% of whites).¹

The overall health of this population is exceptionally good. For many diseases/conditions, Asian/Pacific Islanders fare better than their white counterparts.

<i>Top 5 Causes of Death</i>	<i>% of Deaths</i>
1. <i>Heart Disease</i>	25%
2. <i>Cancer</i>	26%
3. <i>Stroke</i>	6%
4. <i>Unintentional Injury</i>	5%
5. <i>Diabetes Mellitus</i>	3%

1. Heart Disease

Heart disease is the number one cause of death for the Asian/Pacific Islander population. The death rate was 106.0 per 100,000 population in 2005; significantly lower than the rate for whites (219.0) and at least 50% less than the death rates for other racial/ethnic groups.²

2. Cancer

The cancer death rate (84.6 per 100,000 populations) is significantly lower than the rate among whites (186.5) and significantly lower than the rates for all other racial/ethnic groups.² Cancer still accounts for over 25% of total deaths in this population. Prevalence and mortality data are available by cancer site below.

**Age-Adjusted Death
Rates per 100,000, Select Primary Sites, Asian/ Pacific
Islanders, Michigan, 2000-2004**

Primary Site	Total	Male	Female
Colon/Rectum	7.9	*	*
Lung	21.8	25.5	19.0
Breast			11.4

* Rate is considered statistically unreliable

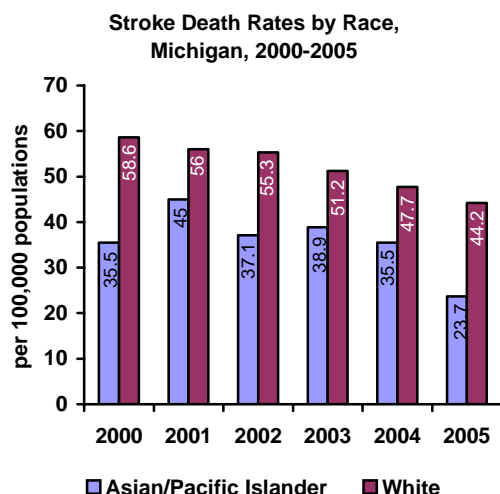
**Age-Adjusted Incidence
Rates per 100,000, Select Primary Sites, Asian/ Pacific
Islanders, Michigan, 2000-2003**

Primary Site	Total	Male	Female
Colon/Rectum	38.7	46.8	31.7
Lung	34.5	45.2	26.0
Breast			61.3
Prostate		92.4	

Source: Michigan Resident Cancer Incidence File, Michigan Resident Death File, Vital Records & Health Data Development Section, Michigan Dept of Community Health

3. Stroke

The 2005 death rate from stroke for the Asian/Pacific Islander population (23.7 per 100,000 population) declined significantly from 2004 (35.5 per 100,000). The rate is significantly lower than rates for other racial/ethnic groups.²



Source: Vital Records & Health Data Development Section, Michigan Department of Community Health

4. Unintentional Injuries

The death rate from unintentional injuries in the Asian/Pacific Islander community is also low in comparison to other racial/ethnic groups. In 2004, the rate of death from this cause was 17.4 per 100,000, almost half the white rate (31.2). The death rate from unintentional injury increased 30% from 2000 to 2004.²

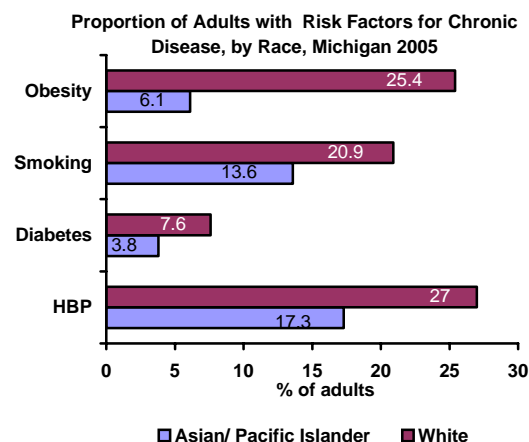
5. Diabetes

Nearly 4% of Asian/Pacific Islander adults has diabetes. This is significantly lower than all other racial and ethnic groups, with the closest group being whites with a prevalence of 7.6%.⁶ Diabetes is the fifth leading cause of death in this population, accounting for 4% of the total deaths. Nineteen deaths were recorded in the year 2004, with 13 deaths in 2005.²

Risk Factors

When looking at risk factors for chronic disease, Asian/Pacific Islanders fare better than whites. For example, 17.3% of Asian/Pacific Islander adults has been told they have high blood pressure (27.0% of whites), 6.1% is obese (25.4% of whites), and 13.6% is a current smoker (20.9% of whites).

However, there are also several risk factors for which the Asian/Pacific Islander population has poor outcomes. Nearly one third of adults (32.3%) has never had their cholesterol checked (19.4% of whites) and 63.4% report getting inadequate physical activity (48.7% of whites).



Source: 2005 Michigan Behavioral Risk Factor Survey

The level of inadequate physical inactivity is highest of all racial/ethnic groups. The same is true for the percentage never having their cholesterol checked. In addition, Asian/Pacific Island adults reported poor healthcare seeking behaviors. While only 10.9% of adults reported that they had no healthcare coverage (13.1% of whites), 25.4% reported no personal health care provider (12.6% of whites), 16.5% reported that cost was an inhibitor to receiving health care (10.9% of whites), and 34.6% reported no routine checkup in the past year (30.2% of whites).⁶

Positive Signs

For the leading causes of death, the Asian/Pacific Islander population has better health outcomes than the white population. The rates of physical activity and the percentage with positive health seeking behaviors for this population are low, yet the overall population of Asian/Pacific Islanders remains in better physical health than most comparison groups.

While the health status of Asian/Pacific Islanders is above average, there are certain segments of the population that face greater hardships. It may be of benefit to focus targeted interventions and prevention measures for Asian/Pacific Islanders at these groups.

U.S. Asian American and Pacific Islander Health

Asian/Pacific Islanders are often regarded as the “model minority” in the US, yet, they are not spared from disparities in health care. While the women in this population have the highest life expectancy (85.8 years), longevity varies by subpopulation. Asian Americans are at greatest risk for the following causes of death: cancer, heart disease, stroke, unintentional injury, and diabetes. Asian Americans have a high prevalence of COPD, Hepatitis B, Tuberculosis (TB) and Liver Disease. In fact, the TB rate is 13 times more common among Asian subgroups such as Cambodians, Chinese, Laotians, Koreans, Indians, Vietnamese and Filipinos, than it is in the US population. Also, Hepatitis B can be anywhere from 25 to 75 times more common in immigrants from Cambodia, Laos, Vietnam and China. In the Native Hawaiian or other Pacific Islander population, 16.6% have heart disease, 4.9% have coronary heart disease (CHD) and 18.2% have hypertension. This is in comparison to the 11.4% of whites that have heart disease, the 5.9% that have CHD, and the 2.3% the report having had a stroke.^{16,17}

Quick Facts:

- In 2001, Asian/Pacific Islander (API) women were 1.5 times more likely to have cervical cancer than white women.¹⁸
- API men and women have higher incidence and mortality rates for stomach and liver cancer than the general population.¹⁸
- In 2002, API adults aged 65 and older were 50% less likely to have ever received a pneumonia shot compared to whites in the same group.¹⁸
- APIs are less likely than whites to have suffered a stroke, and also less likely to die from a stroke.¹⁸
- Asian/Pacific Islanders are 20% less likely than whites to die of diabetes.¹⁸
- Overall API adults are less likely than white adults to have heart disease, and to die from it.
- In general API adults have lower rates of being overweight or obese and lower rates of hypertension compared to whites.¹⁸

Chapter 8: Arab Ancestry



Americans of Arab Ancestry, are those whose ethnic origin, descent, roots, heritage or place of birth lies within the Arabic portion of the world.²⁰ This is different from

past classifications. Previously this department referred to Americans of Arab Ancestry as Arab/Chaldean. However, using the ancestry term, encompasses all groups without the distinctions of religious affiliation.

According to 2005 US census, there are 153,843 Americans of Arab Ancestry living in Michigan.¹ This figure is debated, as other population estimates reveal substantially higher numbers. For example, the Arab American Institute, by adjusting for under-reporting, estimates there are 490,000 Americans of Arab Ancestry living in the state. Since the US census began collecting data on Arab Ancestry in 1980, the population has more than doubled in size. A large proportion (80%) resides in three counties within metro Detroit; with the city of Dearborn home to the largest population.²¹

Personal health-related factors play a significant role in determining health outcomes, yet, socio-economic factors are important as well. Among those identifying as of Arab Ancestry on 2005 census, 21.8% had less than a high school diploma (13% of whites), 23.7% live in poverty (9.9% of whites). Yet the unemployment rate for those of Arab Ancestry is only 4.8% (5.8% of whites). Two thirds (66.6%) reported they spoke a language other than English at home, with 29.4% speaking English less than well.¹

Due to the limited number of people of Arab Ancestry living in the state of Michigan, reliable age-adjusted rates for the leading causes of death were not able to be calculated. The most frequent causes of death are displayed here.

Leading Causes of Death

	Number of deaths
All Causes	808
Heart Disease	249
Cancer	189
Diabetes Mellitus	43
Stroke	38
Unintentional Injuries	35
Chronic Lower Respiratory Disease	33
Pneumonia/Influenza	19
Kidney Disease	15
Alzheimer's	14
Homicide	11

Heart Disease and Cancer account for over 50% (54.2) of the deaths in this population.²

While additional data are not available on heart disease, a special cancer study allowed for further analysis of cancer behaviors and risk factors. This survey was administered to adults 40 and over across the state of Michigan.

For all women in Michigan breast cancer is the most common form of cancer. The state would like for at least 80% of all women to receive annual age and risk appropriate breast cancer screenings. Women of Arab Ancestry reported the lowest rates of annual breast screenings for women ages forty and over, at 43.2%. This issue does not appear to be access related as over 90% of respondents indicated that their insurance covered the screening.

Prostate cancer is the cancer most frequently diagnosed amongst men. Nearly 50% (48.3) of men of Arab Ancestry aged 40+, reported having had a PSA in the their lifetime.¹⁹

Smoking rates also appear to be high for this population, with those of Arab Ancestry having the second highest percentage of those who smoke. Yet, within this population, 82.2% have tried to quit in the last year, indicating that most understand the harmful effects that smoking can have.¹⁹

A special health survey was conducted in 2001, with cooperation from the Arab Community Center for Economic and Social Services (ACCESS) to capture information on the health

status of this population. Data from this survey revealed that 48.1% of the population surveyed believed their health was equivalent to that of other communities, while, 22.6% felt that their health was poorer than the health of other communities. Nearly one-half (48.8%) of the population described their health as excellent, very good, or good as compared to others their same age. In terms of health outcomes, 44% of survey participants had been told by a doctor that they were hypertensive, 19.3% of the respondents reported having diabetes, and 11.4% of those participating in the survey reported having some form of cancer.²⁰

While these data do provide some insight into the health status of this population, the data presented above are from a study and have some limitations. There is limited number of data sources for health data for Americans of Arab Ancestry, making analysis of the health status for this population challenging.

Chapter 9: Conclusion

The leading causes of death for among the racial/ethnic minority populations are Heart Disease, Cancer, Stroke, Diabetes, Chronic Lower Respiratory Disease, and Unintentional Injury (see table below).

Rank of the Leading Causes of Death By Race and Disease, Michigan, 2005

White	African Am/ Black	Am.Indian/ Alaska Native	Hispanic Latino	Asian/ Pacific Islander	Arab
Heart	Heart	Cancer Heart	Heart	Heart	Heart
Cancer	Cancer	Disease	Cancer	Cancer	Cancer
CLRD	Stroke	CLRD	Stroke	Stroke	Diabetes
Stroke	Diabetes	Stroke	Diabetes	Injury	Stroke
Injury	Injury	Diabetes	Injury	Diabetes	Injury
Diabetes					

Source: Vital Records & Health Data Development Section, Michigan Department of Community Health. Bolding indicates the racial/ethnic population that has the highest rate of each disease. CLRD: Chronic Lower Respiratory Disease

These are the same leading causes of death experienced by the state as a whole, but the rates for these causes are much higher among some of the minority populations.

Rates per 100,000 of the Leading Causes of Death By Race and Disease, Michigan, 2005

Cause	WH	AA/B	AI/AN	H/L	A/PI
Heart	219	322.7	198.5	158.9	106
Cancer	186.6	225.7	214.3	120.3	84.6
CLRD	43.9	28.1	64.2	22.7	*
Stroke	44.2	61.6	62.4	41	23.7
Injury	32.7	33.4	34.9	28.4	*
Diabetes	24.7	40.0	48.2	36.1	*

Source: Vital Records & Health Data Development Section, Michigan Department of Community Health. Bolding indicates the racial/ethnic population that has the highest rate of each disease. CLRD: Chronic Lower Respiratory Disease

*Arab Ancestry data was not included because age-adjusted rates were not available.

Reducing the morbidity and mortality amongst racial/ethnic minorities for these causes of death will significantly aid in the overall reduction of death rates throughout the state.

The report provides a basic understanding of the disparities in health status many of the racial and ethnic minorities experience in the state of Michigan. This information may leave some feeling overwhelmed, whereas others may feel inspired to make positive changes in their own life and their community. Regardless of the perspective taken, health outcomes for most racial/ethnic minorities are poor and action is needed.

What can you or your organization do? The elimination of health disparities will require enhanced efforts in disease prevention, health promotion and appropriate health care delivery. The following is a list of general recommendations for beginning to mobilize and address the health status and disparities that exist for communities of color in Michigan. This list is not exhaustive, but describes a starting point for those agencies and organizations beginning to address the challenge of improving the health of minority populations:

- *Ensure that there are on-going efforts to increase knowledge of the determinants of health*
- *Develop the infrastructure capacity of community-based organizations*
- *Emphasize behavioral risk-reduction and other prevention strategies in programs*
- *Assist at-risk individuals in accessing programs designed to diagnose and treat conditions early*
- *Increase involvement of local leaders including faith-based and fraternal organizations*
- *Promote interventions that make healthy behavior the expectation in the community.*
- *Identify and utilize evidence-based strategies to promote high quality of care for all populations.*

Equipped with knowledge and desire, strides can be made towards making Michigan a healthier place to live, learn and earn.

Definitions

Health: *A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (World Health Organization)*

Disparity: *A chain of events signified by a difference in (1) environment; (2) access to, utilization of, and quality of care; (3) health status; or (4) a particular health outcome that deserves scrutiny.*

Socioeconomic Status (SES): *A broad term that is used to describe factors about a person's lifestyle including occupation, income, and education. It is important for researchers to consider SES when conducting health studies. This is because people of different SES levels may have very different access to medical care, healthy food, and physical activity opportunities. These are all factors that can affect health and must be accounted for when studying risk of different diseases and conditions.*

Death Rate: *The number of deaths in a specified community divided by the number of people in the community. The death rate is often expressed as the number of deaths per 100,000 of the population per year*

Age-Adjusted Rate: *A weighted average of the age-specific (crude) rates, where the weights are the proportions of persons in the corresponding age groups of a standard million population. The potential confounding effect of age is reduced when comparing age-adjusted rates computed using the same standard population.*

(Disparity) Rate Ratio: *In this text, this measure is used to determine the magnitude of disparity on a racial/ethnic population. The rate ratio is of the age-adjusted race-specific rate for a given disease/condition over the age-adjusted rate for whites.*

Years Potential Life Lost: *A measure of the relative impact of various diseases and lethal forces on society, computed by estimating the years that people would have lived if they had not died prematurely due to injury, cancer, heart disease, or other causes.*

Prevalence: *The total number of cases of a disease in a given population at a specific time.*

Percent Change: *A useful calculation to understand changes in value over time. The percent change is calculated by subtracting the old value from the new, then dividing by the old value and multiplying by 100.*

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